MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2006

DENVER HEALTH MEDICAL PLAN, INC.
777 Bannock Street, MC 6000
Denver, Colorado 80204-4507

NAIC Company Code 95750

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

CERTIFICATE OF COPY

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the Market Conduct Examination Report as of December 31, 2006 for **Denver Health Medical Plans, Inc.** now on file as a record of this office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver on this 28th day of August 2008.

Marcy Morrison
Commissioner of Insurance

Denver Health Medical Plan, Inc.
777 Bannock Street
Denver, Colorado 80204

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2006

Examination Performed by:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Violetta R. Pinkerton, CIE, CPCU, CPIW

State Market Conduct Examiners

May 14, 2008

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Denver Health Medical Plan, Inc. was conducted pursuant to § 10-16-416, C.R.S., which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its offices located at 990 Bannock Street, Denver, Colorado, 80204. The market conduct examination was performed concurrent with a financial examination of the Company and covered the period from January 1, 2006, through December 31, 2006. The scope of the market conduct portion of the examination was limited to Company Operations and Management, Claims, and Utilization Review.

The results of the examination are respectfully submitted by the following market conduct examiners.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, CPCU, CPIW

MARKET CONDUCT EXAMINATION REPORT OF DENVER HEALTH MEDICAL PLAN, INC.

TABLE OF CONTENTS

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners, with the Colorado Division of Insurance (Division), in accordance with Colorado Insurance Law, §§ 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Denver Health Medical Plan, Inc. The information in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the examination was to determine the Company's compliance with Colorado insurance laws related to health maintenance organizations (HMOs). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The market conduct examination covered the period from January 1, 2006, through December 31, 2006.

The examination included review of the following:

Company Operations and Management
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization or product.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of five (5) findings in which the Company did not appear to be in compliance with Colorado laws. The following is a summary of the examiners' findings.

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to timely and correctly pay interest and/or penalty, on claims not processed within the time frames required by Colorado insurance law.

Issue J3: Failure, in some instances, to allow the required time period for submission of required information prior to denial of the claim.

Utilization Review: The examiners identified two (2) areas of concern in their review of the utilization review practices of the Company:

Issue K1: Failure, in some instances, to provide written notification of first level review determinations.

Issue K2: Failure, in some instances, to include all required information in first level review adverse determination notification letters.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

DENVER HEALTH MEDICAL PLAN, INC.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier. [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER THIRTY (30) CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
14,662*	98	98	100%

(*21% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 14,662 electronic claims that had not been paid, denied or settled within thirty (30) calendar days after receipt. Two (2) claims were subsequently removed after they were determined to be duplicates, reducing the sample to ninety-eight (98). It appears the Company is not in compliance with Colorado insurance law in that all ninety-eight (98) of the electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER FORTY-FIVE (45) CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
6,600*	100	100	100%

(*31% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of 100 non-electronic claims from a total summarized population of 6,600 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears that the Company is not in compliance with Colorado insurance law in that all 100 of the non-electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,838*	50	50	100%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 1,838 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that none of the claims in the sample appeared to involve fraud, and all fifty (50) were not paid, denied or settled within the required ninety (90) calendar days after receipt.

Recommendation No.1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to timely and correctly pay interest and/or penalty, on claims not processed within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. …

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER THIRTY (30) CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
14,662*	98	25	26%

(*21% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 14,662 electronic claims that had not been paid, denied or settled within thirty (30) days after receipt. Two (2) claims were subsequently removed after they were determined to be duplicates, reducing the sample to ninety-eight (98). It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest to either the provider or the insured on twenty-five (25) clean electronic claims that were not paid, denied or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER FORTY-FIVE (45) CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
6,600*	100	18	18%

(*31% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of 100 non-electronic claims from a total summarized population of 6,600 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest, or to pay interest timely or correctly on eighteen (18) clean non-electronic claims that were not paid, denied or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER NINETY (90) CALENDAR DAYS
PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,838*	50	11	22%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 1,838 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay a ten percent (10%) penalty on the total amount ultimately allowed on the claim to the insured or health care provider on eleven (11) of the claims not paid, denied, or settled within ninety (90) calendar days after receipt.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that interest is paid when due on all claims that are not paid, denied, or settled within the required time frames, and that except where fraud is involved, a 10% penalty is paid on all claims not paid, denied, or settled within ninety (90) calendar days after receipt as required by Colorado insurance law.

Issue J3: Failure, in some instances, to allow the required time period for submission of required information prior to denial of the claim.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphases added.]

DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
21,305*	100	11	11%

The examiners reviewed a randomly selected sample of 100 claims from a total summarized population of 21,305 claims that had been denied during the examination period. It appears the Company is not in compliance with Colorado insurance law in that eleven (11) of the claims were denied at the same time additional information needed to adjudicate the claim was requested, without waiting the required thirty (30) calendar days for the additional information to be submitted. Further, the Company has explained verbally and in writing that it has a business practice of denying any claim needing additional information to determine its liability. The Remittance Advice issued in connection with the denial of a claim includes this statement on the back explaining this practice to the provider with instructions on resubmitting the claim: "If claim has been denied for the lack of proper coding or other additional information needed to comprise a clean and complete claim a provider may resubmit the corrected claim with the necessary information to have it reconsidered for adjudication purposes." When the claim is resubmitted with the needed information, the Company opens a new claim with a new claim number and processes as a new claim.

Colorado's prompt claim payment law allows a Company to deny claims that require additional information (unclean claims) only after notifying the appropriate person of the information required and allowing thirty (30) calendar days from the date the notice is received for the information to be provided.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that any additional information required to resolve a claim is requested within thirty (30) calendar days after receipt of the claim, and the person from whom the information is requested is given thirty (30) calendar days to provide the information as required by Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to provide written notification of first level review determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

G. Notification Requirements

(1) *A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph (2) or (3).*

(2) With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, *but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review.*

(3) With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, *but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review.*

H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Section G., *the time period shall begin on the date the grievance requesting review is filed with the health carrier in accordance with the health carrier's procedures or filing a request without regard to whether all of the information necessary to make the determination accompanies the filing*. [Emphases added.]

FIRST LEVEL REVIEW DETERMINATIONS
WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
4	4	1	25%

The examiners reviewed the entire population of four (4) 1st level review files initiated by "covered persons" or their representatives during the examination period. Each of the four (4) 1st level review files appeared to be subject to the provisions of Section 10 of Regulation 4-2-17.

It appears that the Company did not meet the requirements of Colorado insurance law in that in one (1) of the four (4) 1st level review files reviewed, the Company's written notification letter was not provided to the covered person within the thirty (30) day maximum time frame set forth in Colorado Insurance Regulation 4-2-17(10). Although the Company requested an extension from the member in this instance, there is no provision for granting an extension under the Regulation.

Recommendation No.4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notification is provided for all utilization review adverse determinations as required by Colorado insurance law.

Issue K2: Failure, in some instances, to include all required information in first level review adverse determination notification letters.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10. First Level Review

J. A first level review decision involving an adverse determination issued pursuant to Subsection G. shall include, in addition to the requirements of Subsection I.:

1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection F.2., to the covered person's benefit request;

3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criteria to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

5. If applicable, instructions for requesting:

   a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Paragraph 3. of this subsection; and

   b. The written statement of the scientific or clinical rationale for the determination, as provided in Paragraph 4. of this subsection

6. A description of the process to obtain a voluntary second level review, including:

a. The written procedures governing the voluntary second level review, including any require time frame for the review;

b. The right of the covered person to:

(i) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;

(ii) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practical;

(iii) Present written comments documents, records and other materials relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;

a. A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) days prior to the date of the review meeting.

b. Any new material developed after the five-day deadline shall be provided to the carrier when practical;

(iv) Present the covered person's case to the reviewer or review panel;

(v) If applicable, ask questions of the reviewer or review panel; and

(vi) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;

c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process or selecting the decision maker, and the impartiality of the decision maker.

d. A description of the procedure for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

FIRST LEVEL REVIEW ADVERSE DETERMINATION NOTIFICATION LETTERS

Population	Sample Size	Number of Exceptions	Percentage to Sample
4	4	1	25%

The examiners reviewed the entire population of four (4) 1st level review files initiated by "covered persons" or their representatives during the examination period. Each of the four (4) files reviewed appeared to be subject to the provisions of Section 10 of Regulation 4-2-17.

It appears that the Company did not meet the requirements of Colorado insurance law in that the Company's written notification of an adverse determination in one (1) file did not contain any of the required elements reflected in the above referenced Regulation.

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notifications of first level review decisions contain all information required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.	1	11
Issue J2: Failure, in some instances, to timely and correctly pay interest and/or penalty, on claims not processed within the time frames required by Colorado insurance law.	2	13
Issue J3: Failure, in some instances, to allow the required time period for submission of required information prior to denial of the claim.	3	15
UTILIZATION REVIEW		
Issue K1: Failure, in some instances, to provide written notification of first level review determinations.	4	18
Issue K2: Failure, in some instances, to include all required information in first level review adverse determination notification letters.	5	21

State Market Conduct Examiners

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participated in this examination and in the preparation of this report.